CLIENT TREATMENT PLAN

Date: _____ **Next Review Date:** _____

Client Long Term Goals: (use client direct quote)

Short-term Goals / Objectives: Must be **SMART**: **S**pecific, **M**easurable/Quantifiable, **A**ttainable within the Treatment Plan review period, **R**ealistic, and **T**ime-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # 1 Assigning Date: _____

Clinical Interventions: Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ TBS ☐ DTI ☐ DR

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Short-term Goals / Objectives:

Objective # 2 Assigning Date: _____

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ TBS ☐ DTI ☐ DR

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

*MHS includes therapy/rehab (individual, family, or group), collateral and, in some instances, plan development services.

Interpretation

Prefer a language other than English: ☐ Yes ☐ No This plan was interpreted: ☐ Yes ☐ No Language: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

CLIENT TREATMENT PLAN

CLIENT TREATMENT PLAN

- **Except for Medicare, a signature on line (A) OR (B) is REQUIRED for ALL objectives.**
- Signer or Co-Signer must meet Scope of Practice and Procedure Codes Manual requirements.
- Signatures must be obtained when objectives are created (both initial and additional) and at each review period.
- One signature block can be used for multiple objectives created on the same day if the objectives are within the scope of the signator.

Objective Number(s) 1 & 2	(A) PhD/PsyD, LCSW, MFT, RN, CNS	Licensed or registered and waivered PhD/PsyD, licensed or registered/waivered Social Worker and MFT, RN, registered CNS. **Signature minimally signifies consultation/discussion w/service delivery staff.**
	(B) MD/DO, NP	MD/DO or NP required for objectives associated with Medication Support Services. **MD/DO required for any service claiming to Medicare for Directly-Operated; signature minimally signifies consultation/discussion w/service delivery staff.**
	(C) All Other Staff/Title	Used for any staff not holding one of the licenses or registrations above. Second signature required.
	(D) Client*	Document reason for lack of signature below. Signature should be obtained as soon as possible with regular updates in Progress Notes until obtained.
	(E) Client Collateral*	Preferred: Parent, Authorized Caregiver, Guardian, Conservator, or Personal Representative for treatment.

*The signature of the individual signing the Consent for Services is preferred. If unavailable, the signature of one of the client collaterals is permissible.

Objective Number(s) ______	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	All Other Staff/Title		Date:
	Client*		Date:
	Client Collateral*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective Number(s) ______	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	All Other Staff/Title		Date:
	Client*		Date:
	Client Collateral*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective Number(s) ______	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	All Other Staff/Title		Date:
	Client*		Date:
	Client Collateral*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

CLIENT TREATMENT PLAN